DEPARTMENT OF HEALTH CARE SERVICES

REVIEW OF MEDI-CAL MANAGEMENT SYSTEM

March 1973

ASSEMBLYMEN
CHAIRMAN
VINCENT THOMAS
SIXTY-EIGHTH DISTRICT
MIKE CULLEN
FORTY-FOURTH DISTRICT
RAY E. JOHNSON
FOURTH DISTRICT

Joint Legislative Audit Committee

GOVERNMENT CODE: SECTIONS 10500–10504

California Legislature

SENATORS
VICE CHAIRMAN
WILLIAM E. COOMBS
TWENTIETH DISTRICT
GEORGE DEUKMEJIAN
THIRTY-SEVENTH DISTRICT
GEORGE N. ZENOVICH
SIXTEENTH DISTRICT

VINCENT THOMAS
CHAIRMAN
ROOM 4126, STATE CAPITOL
SACRAMENTO, CALIFORNIA 95814
(916) 445-7906
WALTER J. QUINN, C.P.A., COORDINATOR
(916) 445-1890
BILL PETTITE, CONSULTANT
(916) 445-7906
EVE OSTOJA, COMMITTEE SECRETARY
(916) 445-7908

April 2, 1973

The Honorable President of the Senate
The Honorable Speaker of the Assembly
The Honorable Members of the Senate and
The Assembly of the Legislature of California

Members:

Transmitted herewith is a report on a review of the operations of the Medi-Cal Management System. In excess of $10 million has been spent through January 31, 1973, in the development, implementation, and prototype operations. Of this total, $5.6 million for the development and implementation of the system and $3.5 million for prototype operations were paid to Health Care Services Administrators, a joint venture of three insurance companies.

The 1972-73 state budget provided $2,554,728 to be paid to Health Care Services Administrators for the prototype operations of MMS for the period from August 1, 1972 through June 30, 1973. Approximately $3.5 million was paid to Health Care Services Administrators for the prototype operations through January 31, 1973, and it is estimated that an additional $3.5 million will be required to operate the system through June 30, 1973, for a total expenditure of $7 million which will be $4.5 million in excess of the budgeted amount for 1972-73.

Accounting controls over claims processing procedures are inadequate. Payments are being duplicated, paid to wrong providers, and paid in excess of allowable amounts. Procedures have been developed which encourage improper disbursement of funds. Clerical personnel make major decisions in overriding programmed computer controls resulting in payments which are not reviewed or audited.

In order to process claims, fictitious beneficiary names (39 John Does and 32 Jane Does) and over 60,000 fictitious beneficiary identification numbers have been introduced into the system. This prevents the identification of duplicate claims within the system and has made it difficult, and in some cases impossible, for providers to identify payments received with the services rendered individuals.

Payments through the system have been very slow with some claims entered in the system in August and September 1972 still unpaid. To relieve pressure from providers for payments, the Department of Health Care Services issued approximately $12 million in interim or advance, payments to providers in October and November 1972. To speed up payments to providers, many of the system's controls have been relaxed or abandoned.

The Department of Health Care Services failed to give full consideration to the problems of the counties in the design of the eligibility subsystem. As a result, the system is still experiencing problems with the eligibility file. Control over issuances of Medi-Cal identification cards is lax and many instances were noted where two and three cards were issued to the same individual for the same period of eligibility.

There are still unresolved program problems within the system. Required reports are not being produced accurately. System changes have been approved by personnel at the Department of Health Care Services, who has neither the training or experience to fully comprehend the effects of these changes on the total system.

The contract between the Department of Health Care Services and Health Care Services Administrators provided for a retention of ten percent of all billings for the development of MMS until the state was satisfied with the system. The amount retained, $545,101, was disbursed by the Department of Health Care Services on March 14, 1973. The nature of this report indicates that this payment was premature.

Respectfully submitted,

Vincent Thomas

VINCENT THOMAS, Chairman
Joint Legislative Audit Committee

TABLE OF CONTENTS

SUMMARY OF REVIEW

We have reviewed the operations of the Medi-Cal Management System (MMS) for the period from the beginning of the prototype operations in San Diego and Santa Clara counties on August 1, 1972 through January 31, 1973. We also reviewed the disbursements of funds for the development and implementation of the system.

The system is administered by Health Care Services Administrators (HCSA) through a contract with the Department of Health Care Services (DHCS). HCSA is a joint venture involving Pacific Mutual Life Insurance Company, Occidental Life Insurance Company of California and California-Western States Life Insurance Company.

MMS was designed to process claims of providers for services rendered eligible beneficiaries under the Medi-Cal program. For a more detailed discussion of the background of the Medi-Cal program and of MMS, refer to the section of this report entitled, "MMS Background".

The total costs of development, implementation, and prototype operations through January 31, 1973, exceeded $10 million. Of this amount, $5.6 million was attributed to development and implementation. Costs of approximately $3.5 million were disbursed to HCSA for prototype operations from August 1, 1972 through January 31, 1973, and the remainder of the costs consisted of DHCS and county administrative costs.

The contract specified that ten percent of all billings for the development of the system would be retained by the state until acceptance of the system. On March 14, 1973, DHCS disbursed the ten percent retention. In our opinion this payment was premature.

The prototype operations of HCSA were budgeted at $2,554,728 for the period August 1, 1972 through June 30, 1973. Approximately $3.5 million was expended for these operations through January 31, 1973 and it is estimated that another $3.5 million will be required for the period from January 31, 1973 through June 30, 1973. These costs do not include DHCS and county administrative expenses or State Controller's costs to disburse the funds.

The accounting procedures used by the Department of Health Care Services do not facilitate identification of costs by programs. We were able to identify costs of $773,000 attributed to the MMS program. Total identifiable costs of the program are shown in Exhibit II, Statement of Source and Application of Funds, in this report.

The following findings and conclusions were developed during this review.

FINDINGS

CLAIMS PAYMENT PROCEDURES

A significant objective envisioned in the development of the Medical Management System was to achieve computer capability to pre-audit claims against predetermined and programmed criteria. Such pre-audits were to assure that erroneous payments would not be made and that payments would only be made to those providers who had actually performed services for eligible beneficiaries.

FINDING

1. PAYMENTS FOR CLAIMS ARE BEING DUPLICATED, PAID TO WRONG PROVIDERS, AND ARE BEING MADE IN EXCESS OF ALLOWABLE AMOUNTS.

Duplicate Payments

Claims which have been rejected by the computer because they have been identified as being possible or absolute duplicates of claims which have already been paid are being reprocessed and paid. To accomplish this, the claims review clerks are instructing the computer input operators, through coding on the claims, to override the computer rejection and to process and pay the claims.

In excess of $180,000 of checks for services provided has been returned by providers and redeposited in the Health Care Deposit Fund. Payments to providers have in many cases been extremely slow with some unpaid claims still in the system for services rendered in August 1972. We were not able to estimate

the magnitude of erroneous payments nor do we know to what extent erroneous payments have been returned.

Payments to Wrong Providers

Payments are being made to wrong providers because of clerical errors by personnel in the provider's offices and by computer input personnel. The provider identification number check digit, determined by an arithmetic calculation, is the system check to assure that the correct provider is paid. The instructions to input operators have been modified and the entering of the check digit is now optional. The check digit is not entered unless it has been recorded on the claim by the provider.

A number of the checks included in the $180,000 discussed under duplicate payments were returned because payment had been made to the wrong provider. We did not attempt to develop an estimate of the magnitude of payments to wrong providers.

Payments For Services Provided To Ineligible Persons

The computer programmed controls to reject claims, because the individual who received services is not an eligible Medi-Cal beneficiary, have been modified and overridden.

At present, if a beneficiary is not on the eligibility file, but a "sticky label" is attached to the claim, the sticky label is considered proof of eligibility and the claim is processed. Where claims have been rejected because the period of eligibility does not cover the date that services were provided, the claims have been processed and paid. HCSA personnel stated that

the reason for this is that services were provided on the assumption by the provider that the services would be covered under the Medi-Cal program and, therefore, the state has a moral obligation to pay the provider.

FINDING

2. PROCEDURES HAVE BEEN DEVELOPED WHICH ENCOURAGE IMPROPER DISBURSEMENT OF FUNDS.

Hospital Summary Billing

A contractually required item in the claims processing system to be developed by HCSA was the capability to process itemized claims from hospitals and to verify the propriety of each line item to prevent excess and duplicate payments and to assure that all services included on the claim are covered by the Medi-Cal program. Itemized claims processing has been abandoned. At present, the claims are being processed in total, or summary, and a special procedure code is used to bypass programmed controls and to assure that the claim will be processed and paid.

Positive Adjustments

There were no procedures in the system as originally designed to permit additional payments where the amounts paid were less than the correct allowable amounts due to coding errors or where peer review allowed payment of an amount in excess of the normal allowable limits.

To compensate for the deficiency, a procedure was devised to manually prepare "positive adjustments". This procedure consists of a claim review clerk

preparing a new claim form. A special procedure code is used which overrides all programmed instruction to reject the claim.

There are virtually no controls over this procedure. No approval of claims initiated is required and it is impossible, from data available in the computer, to identify the positive adjustments to the original claim.

The manner in which this procedure has been initiated and the lack of controls over its use provides unlimited opportunities for improper disbursement of funds due to either honest mistakes or deliberate fraud.

OPERATIONAL CONTROLS

Operational controls include those functions which safeguard access to the physical premises, protect the programs and data files from destruction in the event of fire or natural disaster, insure the confidentiality of data, prevent the fraudulent utilization of benefits by unauthorized individuals, and those which regulate the use of discretionary action on the part of MMS employees.

ACCESS CONTROL

The access control maintained over the physical premises at the central processing site and at the Local Input and Review Centers (LIRC's) is excellent and Health Care Systems Administrators should be commended for this aspect of their operation.

CONFIDENTIALITY OF DATA

The use of several levels of security codes (passwords) to prevent unauthorized access to confidential files has been well implemented in MMS.

SYSTEMS DOCUMENTATION

The systems documentation including changes to the system is generally excellent.

FINDING

3. TAPE AND DISC STORAGE FACILITIES ARE INADEQUATE.

Data File and Program Protection

The tape and disc library was found to be disorganized, without fire suppression equipment, unattended and poorly cataloged. No offsite backup of programs and data files is maintained. This is a serious violation of common EDP security procedures.

FINDING

4. CONTROLS OVER ISSUANCE OF IDENTIFICATION CARDS ARE LAX.

Unauthorized Utilization of Benefits

The possession of a Medi-Cal I.D. card and the attached labels are a guarantee that the state will pay a provider for services rendered to the holder of the card. There is a serious lack of control over the issuance of temporary and regular I.D. cards.

The pend reason code 161 (beneficiary not eligible) is being automatically overridden and the sticky label is therefore being accepted as proof of eligibility rather than verification with the MMS eligibility file.

Instances where duplicate I.D. cards and duplicate labels are being issued are not unusual and cases of three cards to one beneficiary in one month have been detected.

The Social Welfare Finance officer in San Diego County has collected thousands of Medi-Cal I.D. cards which have been returned as "undeliverable" by the post office. The county has been waiting since September for instructions from MMS personnel as to their disposition.

FINDING

5. CLERICAL PERSONNEL HAVE EXCESSIVE LATITUDE IN OVERRIDING COMPUTER CONTROLS.

Regulating Discretionary Actions by MMS Personnel

The authority delegated to claims review clerks at the Local Input and Review Centers without subsequent audit and review is perhaps the greatest single problem in the area of operational controls.

The claims review clerk is allowed to code claims to override computer rejection and to pay claims which the system has pended due to problems detected in one or more of the validation checks. Claims which have been identified by the system as absolute duplicates of claims which have already been processed may be, and are, reprocessed and paid by the claims review clerk overriding the pend action which identified the claims as duplicates.

The final system specifications states that "absolute duplicates" will be disallowed and not pended. However, HCSA chose to change this feature of the system until MMS was through its early implementation stages. We have been informed by HCSA personnel that as a result of our review "absolute duplicate" claims are now being disallowed and not pended.

No audit of paid and pended claims is being performed. If such a function is initiated, it should include an analysis of the actions and results of claims review personnel.

FINDING

6. SYSTEM AND PROGRAMMING REVISIONS HAVE BEEN MADE TO RELAX CONTROLS TO REDUCE THE CLAIMS BACKLOG.

Special Claims Payment Module

A special version of module MMPAFU was written and implemented on October 29, 1972 in an attempt to reduce the pended claims backlog. This program provided automatic override of certain pend codes and its use resulted in the payment of 5,320 claims in the amount of $569,417.65.

These claims could not have been paid if the prescribed system controls had been left intact.

Automatic Override of Pend Reason Codes

A series of program changes have been approved by DHCS and implemented in the MMS which provide automatic override of 13 pend reasons applied to new or reviewed claims. These pend reasons control the settlement of claims and their automatic override allows claims to be paid which do not meet established payment criteria. The codes involved pertain to the evaluation of claims in areas of eligibility, model treatment profile, diagnosis, emergency authorization, other coverage, etc. and their automatic override seriously reduces the credibility of the system.

Program Changes Authorized by State Personnel

An analysis of the Request for Investigation (RFI) documents used by HCSA to obtain state approval of proposed program changes produced a large collection of authorizing state signatures.

An investigation of the organizational assignment of these individuals indicates that state approval was often relegated to individuals below the position of project director. An analysis of their professional qualifications indicates a minimum of data processing and business experience in many instances, and a definite lack of formalized training in accounting which should be a requisite for individuals authorizing changes to a system as large and complex as MMS.

FINDING

7. SYSTEM REPORTS ARE NOT AVAILABLE.

Repeated Requests to DHCS for Copies Of MMS Reports Which Are a Deliverable Item Have Not Been Met

System specifications stipulate that a large variety of daily, weekly, monthly and quarterly reports will be produced and delivered to DHCS. We have repeatedly made requests to inspect the accuracy of these reports and indeed their very existence, but DHCS is unable or unwilling to comply. These requests were made individually to the MMS project director on two occasions, and collectively to departmental management and HCSA personnel at the audit exit interview. As of the cut-off date for this report, March 26, 1973, the

requests had not been fulfilled. We must conclude that the contractually required reports are not available or are in such condition that delivery was deemed inadvisable. Our experience with other MMS reports which are produced for use within HCSA was unsatisfactory as they were found to be inaccurate and unreliable.

ELIGIBILITY SYSTEM

Under the Medical Management System (MMS) a file of all eligible Medi-Cal beneficiaries is maintained by Health Care Services Administrators (HCSA). The original and continuing determination of eligibility is performed by the county welfare departments who notify HCSA of their determination and who maintain their own eligibility files.

HCSA prepares and mails identification cards to all eligible beneficiaries once each month. The purpose of these procedures is to assure that Medi-Cal benefits are available only to persons entitled to them.

FINDING

8. THE SYSTEM IS STILL EXPERIENCING DIFFICULTIES FROM PROBLEMS GENERATED DURING EARLY PROTOTYPE OPERATIONS IN ESTABLISHING AND MAINTAINING A CURRENT ELIGIBLE BENEFICIARY FILE.

Fictitious Names

HCSA was not able to maintain an accurate and current eligible beneficiary file during the first months of their operation. To correct this, their eligibility files were replaced with current county eligibility files on several occasions.

Claims were subsequently received by HCSA with apparently valid beneficiary identification numbers, but no names, and for periods prior to the

replacement of the eligibility file. HCSA had no record of individuals who had been eligible, but were not presently eligible, for Medi-Cal benefits. The computer would not process claims without beneficiary names.

In order to process these claims, HCSA assigned fictitious beneficiary names to these claims. Our review disclosed 39 John Does and 32 Jane Does. We did not determine whether or not other fictitious names were used or how many.

The fictitious names were used throughout the system and appeared on the remittance advices, Statements of Medical Benefits, accompanying payments to providers. It was therefore difficult, if not impossible, for the providers to identify the beneficiary covered by the remittance.

Fictitious Beneficiary Identification Numbers

The social security account number was selected as the number to be used for identifying beneficiaries under this system. The selection of this number required the assignment of fictitious numbers in certain instances.

- Children and other beneficiaries without SSA numbers - Approximately 50,000 fictitious numbers have been assigned to individuals in this category.

- Out-of-county beneficiaries - Approximately 16,000 fictitious numbers were assigned to beneficiaries from other counties who received service from providers within the prototype counties and for whom no social security account number was available.

Our review disclosed that approximately 5,000 of these out-of-county beneficiary numbers were assigned to beneficiaries who resided within the prototype counties. We were informed by HCSA personnel that these were beneficiaries who were only eligible for Medi-Cal benefits for a short period of time and received services on a one-time basis only.

Adequate control has not been maintained over the assignment of these numbers and instances were noted where individuals were assigned more than one number. Complete claim histories of these beneficiaries are not available and it is possible that undetected duplicate payments to providers have been made.

Multiple Beneficiary Identification Cards

At the time that beneficiaries apply for benefits under the Medi-Cal program, the county welfare office prepares temporary identification cards to enable the beneficiaries to receive immediate care. The county welfare department notifies HCSA of their eligibility determination and HCSA prepares and mails beneficiary identification cards on a daily basis to those individuals added to the eligibility file throughout the month. Monthly HCSA prepares new identification cards for all eligible beneficiaries. Many instances were found where individuals received two and three identification cards for the same period of time.

FINDING

9. DHCS FAILED TO CONSIDER COUNTY PROBLEMS IN THE DESIGN OF THE MMS ELIGIBILITY SUBSYSTEM.

Relations Between County Welfare Departments and HCSA and Department of Health Care Services

The problems existing today between the MMS eligibility sub-system and the prototype counties' welfare eligibility files are the direct result of the lack of communication between the Department of Health Care Services (DHCS) and the county welfare offices during the conceptual stages of MMS.

Repeated attempts by the prototype counties and their technical representative, Alpha Beta Associates, to discuss potential problem areas in the MMS design were ignored by DHCS and HCSA.

Documented evidence in the form of correspondence is abundant which clearly substantiates the counties' requests for participation and inclusion in the design activity; however, DHCS was apparently not interested in encouraging or allowing county participation.

EFFECT OF MMS ON PROVIDERS

The MMS system function specifications included design objectives to establish and maintain professional relationships with providers of services and to process claims promptly, accurately and economically.

FINDING

10. PAYMENTS TO PROVIDERS UNDER MMS HAVE BEEN DELAYED, ERRONEOUS AND DIFFICULT, IF NOT IMPOSSIBLE, TO IDENTIFY TO SERVICES RENDERED.

Delayed Payments

Payment to providers have been delayed for long periods of time. There are still claims within the system which were submitted in August and September 1972 and have not been paid. This problem became so urgent during the early phases of MMS prototype operations that approximately $12 million in advance, or interim, payments were made to providers in the months of October and November 1972. As claims were later processed, the amounts were offset against the advance payments. At January 31, 1973, $800,000 of advance payments were still outstanding.

Matching of Payments to Beneficiaries and Services

Statements of Medi-Cal Benefits (SOMB's), the remittance advices accompanying the checks to providers, have been delivered to providers where

fictitious names and identification numbers assigned by HCSA were used in lieu of the beneficiary's real name and identification number, and on some SOMB's no names were listed. In many cases, this has made it virtually impossible for the provider to match the payments received with the beneficiaries and the services provided.

Duplicate Payments and Payments To Wrong Providers

Payments for services have been duplicated and paid to wrong providers which, together with the delay in payments, have compounded the problems providers have in matching payments received with services provided individuals.

Communication With Providers

We reviewed correspondence which showed that on numerous occasions providers have attempted to communicate with the Department of Health Care Services and Health Care Services Administration personnel and have been referred from one employee to another, promised answers and action, and received no satisfaction.

ACCOUNTING PROCEDURES

The accounting records for the administration of HCSA are maintained on a manual basis by a separate unit physically removed from the claims processing operations. Although claims processing is basically an accounting function, none of the personnel administering the claims processing operation have an accounting background.

FINDING

11. ADEQUATE ACCOUNTING CONTROLS ARE NOT BEING MAINTAINED OVER CLAIMS PROCESSING.

Claims Processing

On January 30, 1973, we requested a reconciliation from HCSA of all claims received and their current disposition. HCSA was unable to provide us with such a reconciliation. We have attempted to prepare such a reconciliation from the records available by summarizing daily reports prepared by HCSA.

We found that the records and reports prepared and maintained were incomplete and inaccurate. We did not have sufficient time to perform an in-depth audit of the supporting documentation behind all reports.

During the course of our review, HCSA was also attempting to prepare a reconciliation. On March 15, 1973, we obtained documentation of the results of their attempt. Exhibit I, "Reconciliation of Claims Received and Processed", discloses that attempts to reconcile the number and amount of claims have produced unlocated differences.

EXHIBIT I

Reconciliation of Claims
Received and Processed by MMS
August 1, 1972 through January 31, 1973

	Prepared By HCSA		Prepared By Auditor General	
	Number	Amount	Number	Amount
Total Claims Received	1,124,404			
Less: Claims Unentered	11,639			
Total Claims Entered	1,112,765	$46,016,594.53	1,131,784	$50,892,624.61
Less Claims Purged And Re-entered (Note)	-	-	20,620	4,876,030.08
Adjusted Total Claims Received	1,112,765	46,016,594.53	1,111,164	46,016,594.53
Claims Rejected By Edit	31,333	901,260.25	29,444	857,567.50
Claims Paid	1,038,517	38,846,272.59	994,517	38,233,698.37
Pricing Cutbacks		4,291,196.65		4,255,689.04
Remainder	42,915	1,977,865.04	87,203	2,669,639.62
Inventory of Claims Pended Per HCSA at January 31, 1973	43,025	1,514,457.00	43,025	1,514,457.00
Unlocated Differences	(110)	$ 463,408.04	44,178	$ 1,155,282.62

Note - The number of claims purged and reentered was available, but the amount of $4,876,030.08 was used in our attempted reconciliation to balance with the adjusted total of claims received.

SOURCE AND APPLICATION OF FUNDS

Exhibit II illustrates the sources and application of funds for development, implementation, and prototype operations of the Medi-Cal Management System from August 1968 through January 1973. The budgeted amounts reported were obtained from annual Budget Reports prepared by the Department of Health Care Services. The actual amounts were determined by an audit of the accounts and records maintained by both the Health Care Services Administration (HCSA) and the department. The MMS budgeted funds are included in the total Medi-Cal Program funds appropriated by the Legislature for each of the fiscal years involved.

Total expenditures incurred by the MMS to January 31, 1973 amounted to $10,378,000. On a 50/50 sharing basis, the federal share is $5,189,000 and the state share is $5,189,000.

It is the practice of the DHCS to augment or reduce line-item budgets by transfers of funds from one budget category to another category. During the MMS operation, the net augmentations to the original budgets totaled $724,497. This amount represented transfers made from the fiscal intermediaries and county administrative expenditures to state support expenditures in order to reflect the changes in the original budgets from $9,637,000 to $10,378,000, as shown on Exhibit II.

Medi-Cal Management System Source and Application
Of Funds Budgeted and Actual For Fiscal Years
1968-69 Thru 1972-73 As Of January 31, 1973

	Budget Act	Budgeted	Actual
Source of Funds			
Appropriations to Health Care Deposit Fund (Note 1)			
Item 124, Contract Services With Lockheed	1968	$ 250,000	$ 250,000
Item 141, MMS Survey	1969	771,179	271,179
Item 112, Design, Development, Testing, and Implementation	1970	3,472,979	3,531,115
Item 228, Development and Implementation	1971	2,136,742	2,119,209
Item 232, Development, Implementation, Program Changes, and Prototype Operations	1972	3,006,514	3,482,124
1972-73 Transfer Budget Allotments - Unadjusted		-	724,497
Totals		$9,637,414	$10,378,124
Use of Funds			
Program Expenditures (Note 1)			
Lockheed Study		$ 250,000	$ 207,500
HCSA Contract			
Design, Development and Testing		5,577,072	5,455,844
Implementation		993,571	337,588
Contracted Cost		6,570,643	5,793,432
Prototype Operations		2,554,728	3,485,175
Medi-Cal Program Changes		-	79,130
Reimbursements to the State for Test-time Machine Rental		-	(258,230)
		9,125,371	9,099,507
DHCS Support Services			
MMS Bureau			
Personnel Salaries, Fringe Benefits, and Travel (Note 2)		262,043	287,538
Data Processing Charges		-	15,248
Direct Payments to IBM - MMS Development		-	470,268
		262,043	773,054
Other			
Acquisition of Social Security Numbers			
San Diego County		-	139,252
Santa Clara County		-	158,811
		-	298,063
Totals		$9,637,414	$10,378,124

NOTES:

1. Program expenditure amounts pertain only to Medi-Cal Management System appropriations and expenditures which are included in the overall Medi-Cal program budget for each of the fiscal years involved.

2. This represents only the identifiable expenditures charged to the MMS Bureau. The DHCS accounting system does not provide for the departmentalized cost accounting of income and expenditures. All departmental costs attributable to MMS have not been identified.

DEVELOPMENT AND IMPLEMENTATION COSTS

As of January 31, 1973, the total development and implementation costs amounted to $5,614,332. Details of these HCSA costs on an accrual basis are summarized below:

	Contract Maximum	Total Costs
System design, development and testing	$5,578,211	
Direct expenses	-	$4,316,356
Indirect expenses (24.2% estimate)	-	931,179
Test time		208,309
Total	5,578,211	5,455,844
Implementation	993,571	
Direct expenses	-	296,743
Test time	-	40,845
Total	993,571	337,588
	6,571,782	5,793,432
Add - Medi-Cal program changes	-	79,130
Deduct - Reimbursements to the state for test time machine rental	-	(258,230)
Total	$6,571,782	$5,614,332

The above summary discloses that the total development and implementation cost is less than contract maximum by $957,450.

The MMS contract provides that indirect expenses shall be invoiced and paid at the rate of 24.2 percent of total direct expenses invoiced for each billing period and later adjusted to actual costs. Such indirect expenses shall not exceed $931,179. As indicated in the summary, the estimated indirect expenses that were billed by the HCSA and subsequently paid by the state amounted to a total of $931,179. The indirect expenses actually incurred

and reported by the HCSA as the correct amount payable by the state is $688,902. The result is that the HCSA now owes the state the difference of $242,277, representing the indirect expenses billed in excess of the actual. HCSA officials confirmed to us that the excess payment will be refunded to the state.

PROTOTYPE OPERATING COSTS

Prototype operations began August 1, 1972 in Santa Clara and San Diego counties. Through January 31, 1973, the total prototype operating costs accrued or paid by the state to HCSA amounted to $3,485,175 detailed as follows:

Salaries and fringe benefits	$1,514,382
Subcontract cost - peer review	439,882
Facilities	517,666
Equipment, includes EDP	672,780
General expenses	214,465
System Management fees	126,000
Total	$3,485,175

The DHCS budgeted funds for the MMS prototype operations in the 1972-73 fiscal year amounted to $2,554,728. This budgeted figure was $930,447 less than was already expended on the prototype system up to January 31, 1973. Projected billings of $680,000 per month for the five remaining months of 1972-73 indicate that there is an anticipated cost increase in the funding level of the prctotype operations of approximately $4.5 million for 1972-73. This additional

prototype cost will be charged, when paid in subsequent months, to funds budgeted for the fiscal intermediaries administration in the 1972-73 fiscal year.

FINDING

12. THE COST PER CLAIM PROCESSED AND PAID IS $3.50.

There were 994,742 claims processed and paid by the prototype system from August 1972 through January 1973. Based on the actual prototype cost of $3,485,175 during the same period, the unit cost is $3.50 per claim.

DHCS SUPPORT EXPENDITURES

The accounting system of the Department of Health Care Services does not provide for cost allocation procedures of program expenditures to the several bureaus or units of the department. The accounting records are maintained on a line-item basis so that program expenditures are determined primarily by the location of personnel in the organization. These expenditures consist only of salaries, payroll taxes, other employee benefits, and travel expenses.

The department maintains a control account for administrative expenditures pertaining to the activities of all units in the organization. No cost allocation bases and procedures have been established to fairly distribute these administrative expenses to the bureaus or units of the department. No accounting employee is assigned the responsibility of identifying the various program elements and component costs.

The MMS bureau costs of $287,538 as shown on Exhibit II were identified during the audit from available accounting data of the DHCS. The lack of cost allocation procedures and equitable bases for allocating the expenditures to

the various program activities resulted in an understatement of an undetermined amount of the MMS bureau costs shown on Exhibit I.

FINDING

13. THE STATE HAS PREMATURELY ACCEPTED AND MADE FINAL PAYMENT FOR THE DEVELOPMENT OF THE MEDI-CAL MANAGEMENT SYSTEM

In accordance with contract, the state withholds payment of ten percent of the amount billed and invoiced by the HCSA for development of the system until satisfied with the system.

As of January 31, 1973, the withheld amount totaled to $545,101. On March 14, 1973, the Department of Health Care Services made the final payment of this amount to HCSA. The department, in making the final payment, apparently, has overpaid the HCSA by the amount of $302,824, because it did not deduct from the payment the amount of $242,277 which the HCSA owes the state for excess billings of indirect expenses, as discussed in detail on page 26 of this report.

The following conditions now exist in the MMS:

- Unresolved handling and disposition of operational problems in the computer system

- Lack of proper accounting control over the providers claims processed and paid by the system

- Inability of the system to provide the required reports accurately and timely.

Because of the existence of the above conditions in the MMS, we are of the opinion that the final payment should not have been made until the above conditions were corrected in the system.

MMS BACKGROUND

The California Medical Assistance Program (Medi-Cal) was established by state law on March 1, 1966. The state legislation authorizing the Medi-Cal program is contained in Division 9, Part 3, Chapter 8, of the Welfare and Institutions Code and Title 22 of the California Administrative Code. The administration of the Medi-Cal program is the responsibility of the Department of Health Care Services.

The basic objectives of Medi-Cal are to:

1. Provide basic health care and related medical services to recipients of public assistance and to medically needy persons in California.

2. Upgrade the health of California's population by providing access to necessary medical services for that part of the population whose income and resources are not adequate to meet their needs for medical care.

The first years of the program's operations resulted in numerous administrative and management problems. These problems were recognized and discussed in a report by the Governor's Survey on Efficiency and Cost Control. Subsequently, the Department of Health Care Services requested competitive bids and selected Lockheed Missiles and Space Company to make a thorough study of the Medi-Cal program. The study was completed in April 1969, with Lockheed recommending the development and implementation of a Medi-Cal Management System. The cost of the Lockheed study to the state was $207,500.

In June 1969, the Human Relations Agency Task Force reviewed and analyzed the Lockheed report and recommended that the proposed system be initially implemented on a prototype basis.

Based on the above recommendations, the DHCS requested proposals to design, develop, test, and implement the MMS and the prototype operation. Bids were submitted in November 1969 by four firms. Two firms were eliminated and the other two remaining in competition were the Health Care Systems Administration (HCSA) and Blue Shield/Blue Crosses (present state fiscal intermediaries). The HCSA proposal included IBM as subcontractor for computer systems analysis, design, and programming, while the fiscal intermediaries proposal included Lockheed as subcontractor. HCSA, a joint venture of Occidental Life Insurance, Pacific Mutual Life Insurance, and California-Western States Life Insurance, was selected to develop and implement the MMS.

On June 15, 1970, DHCS entered into a contract with HCSA to develop the proposed system, to operate a prototype system in Santa Clara and San Diego counties, and to install the system statewide.

The contract provided for system design, development, testing and implementation at a maximum contract price of $5,578,211, and also provided for month-to-month operations by the HCSA on a cost-reimbursement-plus-management-fee basis. No contract amounts were quoted for the prototype operation and the statewide conversion of the system.

On August 25, 1971, the contract was amended to provide for an increase in the maximum price by $993,571 and to revise the original schedule of deliverable dates. This revision was a result of a number of reasons which included the inability of the state to meet scheduled dates for supplying the necessary data. The final maximum contract price was established at $6,571,782.

The development phase of MMS was completed after 27 months which covered the period from June 1970 to August 1972. Actual operations in the two prototype counties started on August 1, 1972.

The amended contract provided for commencement of statewide implementation and conversion to MMS to begin in November 1972. The 1972 Budget Act contained restrictive language which stipulated that no funds appropriated for the Health Care Deposit Fund would be used for implementating a statewide Medi-Cal Management System. As a result of this restrictive language in the budget act and unresolved operational problems with MMS, no progress has been made toward statewide implementation.

DESIGN OBJECTIVES

The design objectives of the Medi-Cal management system as defined in section 1.1 of the system functional specification are:

1. To establish and maintain timely, centralized beneficiary eligiblity data

2. To process claims promptly, accurately and economically

3. To detect duplicate claims, over utilization and other potential abuses of the Medi-Cal program

4. To produce timely, accurate reports and statistics to assist in the management and evaluation of the claims processing system

5. To establish and maintain professional relationships with providers of service

6. To minimize the clerical and professional effort involved in claims processing, by using automatic screening of claims and automatic furnishing of the data and profiles needed for manual claim review

7. To be modular in design, permitting rapid adaptation to changes in processing requirements and to fluctuations in volume.

ELIGIBILITY SUB-SYSTEM

The county where the beneficiary resides determines eligibility for medical benefits and is responsible for all input to the eligibility file in the MMS system.

The counties make a daily transmittal of eligibility transactions (adds, deletes, and changes) in the form of a magnetic tape which is sent air freight to the central processing site. These transactions are extracted from the counties' welfare case data system (CDS). In addition, the counties have the option of sending eligibility changes from on-line terminals located in the county welfare offices.

Regardless of the method of transmittal, on-line or tape, the eligibility file is not updated on-line, but instead is recreated during the batch cycle in the evening hours.

Inquiries to the eligibility file can be made from on-line terminals located at the county welfare offices, State Department of Health Care Services, Local Input and Review Centers and the central processing site.

The MMS system uses the Social Security Number (SSN) as the primary beneficiary identification (I.D.) number. County welfare offices have been successful in urging the recipients to obtain a valid SSN from the Social Security Administration. In addition to the valid SSN's, the system also contains approximately 65,000 "dummy" I.D. numbers which are used to identify

children who do not yet possess a valid SSN; out-of-county beneficiaries and medically indigent people who are on Medi-Cal on an irregular basis.

To assist in beneficiary identification, the MMS system contains cross reference inquiry capability by name and county welfare case number.

For each Medi-Cal beneficiary, the MMS produces a monthly I.D. card with the aid category shown and eligibility and treatment labels attached. Also included as part of the I.D. card is a beneficiary Statement of Medical Benefits (SOMB) to show the recipient what benefits were paid in his behalf during the prior month. This is done as an audit technique on provider billings.

On a daily basis, throughout the month, MMS issues temporary I.D. cards for recipients newly certified by the county welfare office, (CWO) and in emergency situations, the CWO can issue temporary I.D. cards themselves if the recipient requires immediate medical treatment.

When the provider completes the medical treatment for the recipient, he removes a treatment label from the recipient's Medi-Cal I.D. card and affixes it to the MMS claim form, codes information concerning diagnosis, procedures, dates of service, and charge information on the document and then mails the claim form to the assigned LIRC for claim processing.

CLAIMS INPUT SUB-SYSTEM

The claims input sub-system handles the entry of claims data from the display type terminal located in each LIRC.

When the claims are received at the mailroom in the LIRC, they are counted and routed to the pre-screening process which checks for valid treatment labels and provider signatures and then assembles the claims into batches of 25.

The next step is the entry of the claims by the input operator on the display terminal using almost a free format technique with a minimum of prompters.

During this process, the system references the eligibility, provider diagnosis, and procedure files in order to perform validation checks on the incoming data; and as error conditions are detected, they are flashed back to the operator for correction and reentry.

Due to the file organization techniques employed in MMS, the terminal response time on the display terminals are excellent. Once the input process has been completed on a claim and the input is accepted by the system, the claim control number is displayed to the terminal operator. This is a unique, computer generated number that identifies a claim throughout its life in MMS. The format of this number is YDDDCCTTSSSS where:

YDDD Is the date the claim entered the system in Julian Form of Y = year and DDD = Julian date (1-366), e.g., 3134 = 134th day of 1973.

EE Identifies the LIRC where the claim was entered.

TTT Identifies the terminal operator. This number is unique for an operator in an input center.

SSSS Is the sequential count of the claims entered by this operator in this center, for this day.

The operator transcribes the claim control number to the claim report document and the entry process is complete.

CLAIMS PROCESSING SUB-SYSTEM

The claims processing sub-system is run as part of the daily sequential (batch) cycle at the conclusion of the daily on-line period.

It processes new claims entered through the claims input sub-system and corrections entered through the claims review sub-system and tests for medical necessity and duplicate claims.

The active claims, claims transaction, claims history, model treatment profile, and broad screen table files are referenced by this sub-system.

Claims are subjected to broad screen analysis which will quickly identify those claims that clearly are eligible for payment because they pass gross limits, and those claims that clearly must be reviewed because they contain diagnosis or procedures that must always be reviewed. Claims that pass these checks are tested against model treatment profiles to determine medical necessity.

Claims that require review are transmitted to the model 2780 terminals located at each LIRC together with the profiles and other data required for review by claims review personnel.

The claims that pass all validation checks are produced and a magnetic tape of SOMB's and payment instruments are produced.

SOMB's for inpatient hospital claims are printed at the central processing site and sent air freight to the State Controller's Office along with the magnetic tape of other SOMB's and payment instruments.

The State Controller's Office prints the payment instruments (warrants) and the noninpatient SOMB's and completes the mailing process to the providers.

Claims for beneficiaries with other insurance coverage are paid in full by MMS and a register of these claim numbers is transmitted to the Recovery Unit in DHCS for collection from the other carriers.

Claims involving Medicare coverage are not handled by MMS, but instead are mailed directly to the fiscal intermediary for Medicare in San Francisco. The one exception to this rule is in Nursing Home Care which is not covered by Medicare so those claims are paid by MMS.

CLAIMS REVIEW SUB-SYSTEM

The claims review sub-system provides for manual processing of claims selected for further review. Human judgment is applied against the original claim, the beneficiary and provider profiles and available reference data in an attempt to settle claims which have exceeded the guidelines that have been applied during the machine process.

There are two levels of review. At the administrative level, a claims review clerk resolves differences between the original claim form and the copy being processed and makes adjustments and provides coding where medical judgment is not required.

At the peer review level, claims requiring medical judgment are reviewed. Corrections and adjustments at this level are entered by the claims review clerk following directions given by peer review.

ADMINISTRATIVE SUB-SYSTEM

The administrative sub-system consists of seven functional areas involving both manual and machine processes which provide the control and support required for the functioning of the claims and eligibility sub-systems.

The Fiscal Area involves payroll, accounting, budgeting, and reporting of income required for MMS operation. The suspense function allows manual disbursement of funds not provided as part of the routine system. The manual payment limit is presently $5,000.00, but is being raised to $99,999.99.

Reference File Maintenance provides capability for making changes to reference files such as the provider, diagnosis, model treatment profile, procedures and drug formulary files.

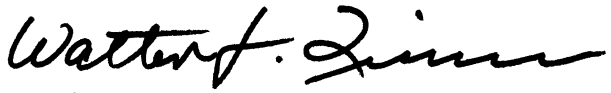
Claims studies provides reports not covered in other sub-systems, such as statistical reports on system operation for management. The quarterly production of provider profiles and provider utilization studies are or will be provided by this area.

Computer System Management controls the hardware and software of the MMS. Capability is provided for start-up, recovery, restart and shut down without loss of data. Physical security is included in this sub-system.

Data Security includes provision for password protection, timelogging of all transactions, and statistical reporting of input operator error rates.

The Support Area provides elements such as operator and provider instruction manuals, provider information bulletins, forms, supplies, correspondence interoffice communication and purchasing.

Exception Processing capability handles all functions that are not part of normal system design. Such exception processing is largely manual; however, it may use system functions. This capability will function as an interim operation in some cases where the regular operation is inoperative or requires change.



Walter J. Quinn
Acting Deputy Auditor General

March 30, 1973

Staff:
John E. Finnstrom
Phillips Baker
Gary S. Ross
Rosauro A. Luna